The House Committee on Rules offers the following substitute to SB 109:

A BILL TO BE ENTITLED

AN ACT

To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to provide certain definitions; to include plan administrators in prompt pay requirements; to provide for penalties; to amend Chapter 4 of Title 26 of the Official Code of Georgia Annotated, the "Georgia Pharmacy Practice Act," so as to provide for regulation and licensure of pharmacy benefits managers by the Commissioner of Insurance; to provide for definitions; to provide for license requirements and filing fees; to provide for requirements and procedures affecting pharmacy benefits managers; to provide for related matters; to provide for effective dates; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by revising Code Section 33-23-100, relating to the definition of administrator, as follows:

"33-23-100.

(a) As used in this article, the term:

(1) 'Administrator' means any business entity that, directly or indirectly, collects charges, fees, or premiums; adjusts or settles claims, including investigating or examining claims or receiving, disbursing, handling, or otherwise being responsible for claim funds; ~~and~~ or provides underwriting or precertification and preauthorization of hospitalizations or medical treatments for residents of this state for or on behalf of any insurer, including business entities that act on behalf of ~~multiple~~ a single or multiple employer self-insurance health ~~plans, and~~ plan or a self-insured ~~municipalities~~ municipality or other political ~~subdivisions~~ subdivision. Licensure is also required for administrators who act on behalf of self-insured plans providing workers' compensation benefits pursuant to Chapter 9 of Title 34. For purposes of this article, each activity undertaken by the administrator on behalf of an insurer or the client of the administrator is considered a transaction and is subject to the provisions of this title.

(2) 'Business entity' means a corporation, association, partnership, sole proprietorship, limited liability company, limited liability partnership, or other legal entity.

(3) 'Standard financial quarter' means a three-month period ending on March 31, June 30, September 30, or December 31 of any calendar year.

(b) Notwithstanding the provisions of subsection (a) of this Code section, the following are exempt from licensure ~~as~~ so long as such entities are acting directly through their officers and employees:

(1) An employer on behalf of its employees or the employees of one or more subsidiary or affiliated corporations of such employer;

(2) A union on behalf of its members;

(3) An insurance company licensed in this state or its affiliate unless the affiliate administrator is placing business with a nonaffiliate insurer not licensed in this state;

(4) An insurer which is not authorized to transact insurance in this state if such insurer is administering a policy lawfully issued by it in and pursuant to the laws of a state in which it is authorized to transact insurance;

(5) A life or accident and sickness insurance agent or broker licensed in this state whose activities are limited exclusively to the sale of insurance;

(6) A creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors;

(7) A trust established in conformity with 29 U.S.C. Section 186 and its trustees, agents, and employees acting thereunder;

(8) A trust exempt from taxation under Section 501(a) of the Internal Revenue Code and its trustees and employees acting thereunder or a custodian and its agents and employees acting pursuant to a custodian account which meets the requirements of Section 401(f) of the Internal Revenue Code;

(9) A bank, credit union, or other financial institution which is subject to supervision or examination by federal or state banking authorities;

(10) A credit card issuing company which advances for and collects premiums or charges from its credit card holders who have authorized it to do so, provided that such company does not adjust or settle claims;

(11) A person who adjusts or settles claims in the normal course of his or her practice or employment as an attorney and who does not collect charges or premiums in connection with life or accident and sickness insurance coverage or annuities;

(12) ~~A business entity that acts solely as an administrator of one or more bona fide employee benefit plans established by an employer or an employee organization, or both, for whom the insurance laws of this state are preempted pursuant to the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq.~~ An insurance

company licensed in this state or its affiliate if such insurance company or its affiliate is solely administering limited benefit insurance. For the purpose of this paragraph, the term 'limited benefit insurance' means accident or sickness insurance designed, advertised, and marketed to supplement major medical insurance, specifically: accident only, CHAMPUS supplement, disability income, fixed indemnity, long-term care, or specified disease; or

(13) An association that administers workers´ compensation claims solely on behalf of its members.

(c) A business entity claiming an exemption shall submit an exemption notice on a form provided by the Commissioner. This form must be signed by an officer of the company and submitted to the department by December 31 of the year prior to the year for which an exemption is to be claimed. Such exemption notice shall be updated in writing within 30 days if the basis for such exemption changes. An administrator claiming an exemption pursuant to paragraphs (3) and (4) of subsection (b) of this Code section shall be subject to the provisions of Code Sections 33-24-59.5 and 33-24-59.13.

(d) Obtaining a license as an administrator does not exempt the applicant from other licensing requirements under this title.

(e) Obtaining a license as an administrator subjects the applicant to the provisions of Code Sections 33-24-59.5 and 33-24-59.13.

(f) An administrator shall be subject to Code Sections 33-24-59.5 and 33-24-59.13 unless the administrator provides sufficient evidence that the self-insured health plan failed to properly fund the plan to allow the administrator to pay any outside claim.″

SECTION 2.

Said title is further amended by revising Code Section 33-24-59.5, relating to timely payment of health benefits, as follows:

″33-24-59.5.

(a) As used in this Code section, the term:

(1) 'Benefits' means the coverages provided by a health benefit plan for financing or delivery of health care goods or services; but such term does not include capitated payment arrangements under managed care plans.

(2) 'Health benefit plan' means any hospital or medical insurance policy or certificate, health care plan contract or certificate, qualified higher deductible health plan, health maintenance organization subscriber contract, any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45, or any dental or vision care plan or policy, or managed care plan or self-insured plan; but health benefit plan does not include

policies issued in accordance with Chapter 31 of this title; disability income policies; or Chapter 9 of Title 34, relating to workers´ compensation.

(3) 'Insurer' means an accident and sickness insurer, fraternal benefit society, nonprofit hospital service corporation, nonprofit medical service corporation, health care corporation, health maintenance organization, provider sponsored health care corporation, or any similar entity and any self-insured health benefit plan ~~not subject to the exclusive jurisdiction of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq.~~, which entity provides for the financing or delivery of health care services through a health benefit plan, the plan administrator of any health plan, or the plan administrator of any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45 or any other administrator as defined in paragraph (1) of subsection (a) of Code Section 33-23-100.

(b)(1) All benefits under a health benefit plan will be payable by the insurer which is obligated to finance or deliver health care services under that plan upon such insurer´s receipt of written or electronic proof of loss or claim for payment for health care goods or services provided. The insurer shall within 15 working days for electronic claims or 30 calendar days for paper claims after such receipt mail or send electronically to the insured or other person claiming payments under the plan payment for such benefits or a letter or electronic notice which states the reasons the insurer may have for failing to pay the claim, either in whole or in part, and which also gives the person so notified a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. Where the insurer disputes a portion of the claim, any undisputed portion of the claim shall be paid by the insurer in accordance with this chapter. When all of the listed documents or other information needed to process the claim has been received by the insurer, the insurer shall then have 15 working days for electronic claims or 30 calendar days for paper claims within which to process and either mail payment for the claim or a letter or notice denying it, in whole or in part, giving the insured or other person claiming payments under the plan the insurer´s reasons for such denial.

(2) Receipt of any proof, claim, or documentation by an entity which administrates or processes claims on behalf of an insurer shall be deemed receipt of the same by the insurer for purposes of this Code section.

(c) Each insurer shall pay to the insured or other person claiming payments under the health benefit plan interest equal to ~~18~~ 12 percent per annum on the proceeds or benefits due under the terms of such plan for failure to comply with subsection (b) of this Code section.

(d) An insurer may only be subject to an administrative penalty by the Commissioner as authorized by the insurance laws of this state when such insurer processes less than 95 percent of all claims in a standard financial quarter in compliance with paragraph (1) of subsection (b) of this Code section. Such penalty shall be assessed on data collected by the Commissioner.

(e) This Code section shall be applicable when an insurer is adjudicating claims for its fully insured business or its business as a third-party administrator.″

SECTION 3.

Said title is further amended in Article 1 of Chapter 24, relating to general provisions concerning insurance, by adding a new Code section to read as follows:

″33-24-59.13.

(a) As used in this Code section, the term:

(1) 'Benefits' shall have the same meaning as provided in Code Section 33-24-59.5.

(2) 'Facility' shall have the same meaning as provided in Code Section 33-20A-3.

(3) 'Health benefit plan' shall have the same meaning as provided in Code Section 33-24-59.5.

(4) 'Health care provider' shall have the same meaning as provided in Code Section 33-20A-3.

(5) 'Insurer' shall have the same meaning as provided in paragraph (3) of Code Section 33-24-59.5.

(b)(1) All benefits under a health benefit plan will be payable by the insurer which is obligated to finance or deliver health care services under that plan upon such insurer´s receipt of written or electronic proof of loss or claim for payment for health care goods or services provided. The insurer shall within 15 working days for electronic claims or 30 calendar days for paper claims after such receipt mail or send electronically to the facility or health care provider claiming payments under the plan payment for such benefits or a letter or notice which states the reasons the insurer may have for failing to pay the claim, either in whole or in part, and which also gives the facility or health care provider so notified a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. Where the insurer disputes a portion of the claim, any undisputed portion of the claim shall be paid by the insurer in accordance with this chapter. When all of the listed documents or other information needed to process the claim has been received by the insurer, the insurer shall then have 15 working days for electronic claims or 30 calendar days for paper claims within which to process and either mail payment for the claim or a letter or notice

denying it, in whole or in part, giving the facility or health care provider claiming payments under the plan the insurer´s reasons for such denial.

(2) Receipt of any proof, claim, or documentation by an entity which administers or processes claims on behalf of an insurer shall be deemed receipt of the same by the insurer for purposes of this Code section.

(c) Each insurer shall pay to the facility or health care provider claiming payments under the health benefit plan interest equal to 12 percent per annum on the proceeds or benefits due under the terms of such plan for failure to comply with subsection (b) of this Code section.

(d) An insurer may only be subject to an administrative penalty by the Commissioner as authorized by the insurance laws of this state when such insurer processes less than 95 percent of all claims in a standard financial quarter in compliance with paragraph (1) of subsection (b) of this Code section. Such penalty shall be assessed on data collected by the Commissioner.

(e) This Code section shall be applicable when an insurer is adjudicating claims for its fully insured business or its business as a third-party administrator.″

SECTION 4.

Chapter 4 of Title 26 of the Official Code of Georgia Annotated, the "Georgia Pharmacy Practice Act," is amended by adding a new article to read as follows:

″ARTICLE 13

26-4-210.

As used in this article, the term:

(1) 'Business entity' means a corporation, association, partnership, sole proprietorship, limited liability company, limited liability partnership, or other legal entity.

(2) 'Commissioner' means the Commissioner of Insurance.

(3) 'Pharmacy benefits manager' means a person, business, or other entity that performs pharmacy benefits management. The term includes a person or entity acting for a pharmacy benefits manager in a contractual or employment relationship in the performance of pharmacy benefits management for a covered entity. This term shall not include a hospital health system operating a formulary process or providing a prescription drug program for the benefit of covered individuals including the hospital health system´s employees and their dependents.

26-4-211.

(a) No business entity shall act as or hold itself out to be a pharmacy benefits manager in this state, other than an applicant licensed in this state for the kinds of business for which it is acting as a pharmacy benefits manager, unless such business entity holds a license as a pharmacy benefits manager issued by the Commissioner. The license shall be renewed on an annual basis and in such manner as the Commissioner may prescribe by rule or regulation. Failure to hold such license shall subject the pharmacy benefits manager to the fines and other appropriate penalties as provided in Chapter 2 of Title 33.

(b) An application for a pharmacy benefits manager´s license or an application for renewal of such license shall be accompanied by a filing fee to be prescribed by rule or regulation of the Commissioner.

(c) A license may be refused or a license duly issued may be suspended or revoked or the renewal of such license refused by the Commissioner if the Commissioner finds that the applicant for or holder of the license:

(1) Has intentionally misrepresented or concealed any material fact in the application for the license;

(2) Has obtained or attempted to obtain the license by misrepresentation, concealment, or other fraud;

(3) Has misappropriated, converted to his or her own use, or illegally withheld money belonging to an insurer or an insured or beneficiary;

(4) Has committed fraudulent practices;

(5) Has materially misrepresented the terms and conditions of insurance policies or contracts;

(6) Has failed to comply with or has violated any proper order, rule, or regulation issued by the Commissioner;

(7) Is not in good faith carrying on business as a pharmacy benefits manager;

(8) Has failed to obtain for initial licensure or retain for annual renewal an adequate net worth as prescribed by order, rule, or regulation of the Commissioner; or

(9) Has shown lack of trustworthiness or lack of competence to act as a pharmacy benefits manager.

(d) If the Commissioner moves to suspend, revoke, or nonrenew a license for a pharmacy benefits manager, the Commissioner shall provide notice of that action to the pharmacy benefits manager and the pharmacy benefits manager may invoke the right to an administrative hearing in accordance with Chapter 2 of Title 33.

(e) No licensee whose license has been revoked as prescribed under this Code section shall be entitled to file another application for a license within five years from the effective date of the revocation or, if judicial review of such revocation is sought, within five years from

the date of final court order or decree affirming the revocation. The application when filed may be refused by the Commissioner unless the applicant shows good cause why the revocation of its license shall not be deemed a bar to the issuance of a new license.

(f) Appeal from any order or decision of the Commissioner made pursuant to this article shall be taken as provided in Chapter 2 of Title 33.

(g)(1) The Commissioner shall have the authority to issue a probationary license to any applicant under this article.

(2) A probationary license may be issued for a period of not less than three months and not longer than 12 months and shall be subject to immediate revocation for cause at any time with a hearing.

(3) The Commissioner, at his or her discretion, shall prescribe the terms of probation, may extend the probationary period, or refuse to grant a license at the end of any probationary period.

(h) A pharmacy benefits manager´s license may not be sold or transferred to a nonaffiliated or otherwise unrelated party. A pharmacy benefits manager may not contract or subcontract any of its negotiated services to any unlicensed business entity unless a special authorization is approved by the Commissioner prior to entering into a contracted or subcontracted arrangement.

(i) The Commissioner may, at his or her discretion, assess a fine of $1,000.00 against any business entity acting as a pharmacy benefits manager without a license for each transaction in violation of this chapter.

(j) A licensed pharmacy benefits manager is not permitted to market or administer any insurance product not approved in Georgia or that is issued by a nonadmitted insurer or unauthorized multiple employer self-insured health plan.″

SECTION 5.

Sections 1, 2, and 3 of this Act shall become effective on January 1, 2009. All other sections shall become effective on July 1, 2008.

SECTION 6.

All laws and parts of laws in conflict with this Act are repealed.